BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
OMID VESAL, M.D.	)	Case No. 800-2014-002645
	)	
Physician's and Surgeon's Certificate No. A 73459	)	
	)	
	)	
Respondent	)	
	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 9, 2017.

IT IS SO ORDERED: October 10, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **OMID VESAL, M.D.** **755 Bunting Circle** **Anaheim Hills, CA 92808** **Physician's and Surgeon's Certificate No. A 73459,** Respondent.	Case No. 800-2014-002645 OAH No. 2017020267 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California (Board) the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Board. She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Chris Leong, Deputy Attorney General.

2. Respondent OMID VESAL, M.D. (Respondent) is represented in this proceeding by attorney John D. Bishop, whose address is: 5000 Birch Street, Suite 7000, Newport Beach, CA 92660.

3. On or about November 9, 2000, the Board issued Physician's and Surgeon's Certificate No. A 73459 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2014-002645, and will expire on February 28, 2018, unless renewed.

JURISDICTION

4. Accusation No. 800-2014-002645 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 13, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2014-002645 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2014-002645. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2014-002645, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

12. Respondent agrees that if he ever petitions for early termination of probation or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2014-002645, shall be deemed true, correct and fully admitted by Respondent for purpose of that proceeding or any other licensing proceeding involving Respondent in the State of California.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 73459 issued to Respondent OMID VESAL, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65

hours of CME of which 40 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the

Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully

complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a

final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

7. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice, shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which

includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules

governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice,

Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the

exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar

year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, John D. Bishop. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/22/17

OMID VESAL, M.D.
Respondent

I have read and fully discussed with Respondent Omid Vesal, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/22/17

JOHN D. BISHOP
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 8/22/2017

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

CHRIS LEONG
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-002645

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: OMID VESAL, M.D. 755 Bunting Circle Anaheim Hills, California 92808 Physician's and Surgeon's Certificate No. A 73459, Respondent.	Case No. 800-2014-002645 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California ("Board").

2. On November 9, 2000, the Board issued Physician's and Surgeon's Certificate Number A 73459 to Omid Vesal, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following sections of the Business and Professions Code ("Code"), Government Code, and Health and Safety Code.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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9. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

10. Section 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

"(3) Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

"(4) Violates Section 2242.1 regarding prescribing on the Internet.

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control

Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5."

11. Health and Safety Code Section 11153 states:

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. . ."

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12. Health and Safety Code Section 11154 states:

"(a) Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division."

"(b) No person shall knowingly solicit, direct, induce, aid, or encourage a practitioner authorized to write a prescription to unlawfully prescribe, administer, dispense, or furnish a controlled substance."

13. Health and Safety Code Section 11156 (a) states:

"Except as provided in Section 2241 of the Code, 'no person shall prescribe for, or administer, or dispense a controlled substance to, an addict'. . .'"

14. Section 2239 of the Code states:

"(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct."

"(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The Division of Medical Quality[1] may order discipline of the licensee in accordance with Section 2227 or the Division of Licensing may order the denial of the license when the time

[1] "Pursuant to Business and Professions Code Section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California."

for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment."

INTRODUCTION

15. This Accusation involves prescriptions for medications regulated by the Comprehensive Drug Abuse Prevention and Control Act, passed into law in 1970. Title II of this law, the Controlled Substances Act, is the legal foundation of narcotics enforcement in the United States. The Controlled Substances Act regulates the manufacture, possession, movement, and distribution of drugs in our country. The Controlled Substances Act places all drugs into one of five schedules, or classifications, and is controlled by the Department of Justice and the Department of Health and Human Services, including the Federal Drug Administration. In 1972, California followed the federal lead by adopting the Uniform Controlled Substance Act. (Government Code §11153 et seq.)

16. The following delineates the five schedules with examples of drugs, medications, and information about each:

Schedule I Drugs

17. These drugs have no safe, accepted medical use in the United States. This schedule includes drugs such as heroin, ecstasy, LSD, and crack cocaine. Schedule I drugs have a high tendency for abuse and have no accepted medical use. Pharmacies do not sell Schedule I drugs, and they are not available with a prescription by a physician.

Schedule II Drugs

18. Schedule II drugs have a high tendency for abuse, may have an accepted medical use, and can produce dependency or addiction with chronic use. Of all legal prescription medications, Schedule II controlled substances have the highest abuse potential. These drugs can cause severe psychological or physical dependence. Schedule II drugs include certain narcotic, stimulant, and

depressant drugs. Examples of Schedule II drugs include cocaine, opium, morphine, fentanyl, amphetamines, and methamphetamines.

19. Schedule II drugs may be available with a prescription by a physician, but not all pharmacies may carry them. These drugs require more stringent records and storage procedures than drugs in Schedules III and IV.

Schedule III Drugs

20. Schedule III drugs have medium tendency for abuse or addiction than drugs in the first two schedules and have a currently accepted medical use. The abuse of Schedule III drugs may lead to moderate to high psychological dependence.

21. Examples of Schedule III drugs include codeine, hydrocodone with acetaminophen, or anabolic steroids. Schedule III drugs may be available with a prescription, but not all pharmacies may carry them.

Schedule IV Drugs

22. Schedule IV drugs have a lower tendency for abuse that leads only to limited physical dependence or psychological dependence relative to drugs in Schedule III. Schedule IV drugs have a currently accepted medical use and have limited addictive properties. Schedule IV drugs have the same restrictions as Schedule III drugs.

23. Examples of Schedule IV drugs include Xanax, valium, phenobarbital, and Rohypnol (commonly known as the "date rape" drug). These drugs may be available with a prescription, but not all pharmacies may carry them.

Schedule V Drugs

24. Schedule V drugs have a lower chance of abuse than Schedule IV drugs, have a currently accepted medical use in the United States, and lesser chance of dependence compared to Schedule IV drugs. This schedule includes such drugs as cough suppressants with codeine.

25. Schedule V drugs are regulated but generally do not require a prescription.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

26. **Hydrocodone/APAP** (Lortab) hydrocodone, and acetaminophen. Acetaminophen, often abbreviated as APAP, is a peripherally acting analgesic agent found in many combination

products and also available by itself. This combination product is used treat moderate to moderately severe pain. In the U.S., formulations containing more than 15 mg hydrocodone per dosage unit are considered Schedule II drugs.

27. **Testosterone**, (Androgel) an anabolic steroid, is a Schedule III controlled substance pursuant to Health and Safety Code 11056, subdivision (f)(30), and a dangerous drug pursuant to Code section 4022.

28. **Alprazolam** is depressant medication. It is a scheduled IV controlled substance as designated by Health and Safety Code Section 11057, subdivision (d)(1), and a dangerous drug pursuant to Code section 4022.

29. **Acetaminophen** with Codeine contains a combination of drugs. Codeine is an opioid pain medication. It is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(G), and a dangerous drug pursuant to Code Section 4022.

30. **Promethazine** with Codeine contains a combination of drugs. Codeine is an opioid pain medication. It is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(G), and a dangerous drug pursuant to Code Section 4022.

31. **Dextroamphetamine**, (Adderall) also known by the brand names "Dexedrine" and "Dextrostat," is used to treat attention-deficit hyperactivity disorder and narcolepsy. It is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055, subdivision (d)(I), and a dangerous drug within the meaning of Business and Professions Code Section 4022.

32. **Zolpidem** (Ambien) is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057, subdivision (d)(32), and a dangerous drug within the meaning of Code Section 4022. It is a depressant drug used for short term treatment of insomnia.

33. **Diazepam** is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057, subdivision (d)(9), and a dangerous drug within the meaning of Code Section 4022. It is a depressant drug.

34. **Carisoprodol** (Soma) is a dangerous drug pursuant to Section 4022 of the Code. It is a Schedule IV controlled substance pursuant to 21 CFR Part 1308. Its generic name is Carisprodol and it is used as a skeletal muscle relaxant.

35. **Lorazepam** (Ativan) is a dangerous drug pursuant to Section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code Section 11057, subdivision (d)(16).

36. **Oxycodone** Acetaminophen is a combination drug. Oxycodone is an opioid, i.e., a synthetic narcotic that resembles the naturally occurring opiates. It is a Schedule II controlled substance, as designated by Health and Safety Code Section 11055, subdivision (b)(1)(M), and a close relative of morphine, heroin, codeine, fentanyl, and methadone it is a dangerous drug within the meaning of Code Section 4022.

37. **Clonazepam** (Klonopin) is a dangerous drug pursuant to Section 4022 of the Code. It is a Schedule IV controlled substance, as designated by Health and Safety Code Section 11057, subdivision (d)(7). It is used in both the prophylaxis and treatment of various seizure disorders. The dosage of Clonazepam should be carefully and slowly adjusted to meet the needs and requirements of the individual. An initial adult dose, however, should not exceed 1.5 mg daily. Adult maintenance dosage should generally not exceed 20 mg daily.

38. **OxyContin** (oxycodone) is an opioid, i.e., a synthetic narcotic that resembles the naturally occurring opiates. It is a Schedule II controlled substance, as designated by Health and Safety Code Section 11055, subdivision (b)(1)(M), and a close relative of morphine, heroin, codeine, fentanyl, and methadone it is a dangerous drug within the meaning of Code Section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

39. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of his patients. The circumstances are as follows:

Prescribing of Controlled Substances Standard of Care

40. The standard of care for prescribing controlled substances requires that the prescribing physician perform a history and physical examination, including where indicated an assessment of the pain complained of and a substance abuse history. The prescribing physician

should create a treatment plan with objectives which can be evaluated as the treatment progresses. Informed consent must be obtained by the prescribing physician, including discussing the risks and benefits of the use of controlled substances. The prescribing physician must periodically review the controlled substance treatment course to determine if the treatment is effective or needs modification. Where indicated, the prescribing physician should consult with other physicians or refer the patients for additional evaluation and treatment. The prescribing physician must maintain accurate and complete records of the care and treatment provided. Except in emergencies, the prescribing physician should not prescribe controlled substances for herself or immediate family members.

Informed Consent

41. Standard of practice dictates that the physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

42. The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

43. The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist.

44. In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion.

Ongoing Monitoring

45. The standard of practice dictates that Respondent monitor the following:

a. Vital Signs - Obtaining blood pressure, pulse (heart rate), temperature, respiratory rate (optional), and weight are standard as part of a visit. This is even more critical for visits in which opioids/ controlled substances are prescribed. These are rarely if even obtained and documented for this patient.

b. Monitoring Pain Relief - Physicians must monitor pain relief as well as physical and psychosocial function. The treating physician must tailor the treatment for the specific patient. Multiple treatment modalities may be required if the pain is complex.

c. Evaluation for Continued Pain Control - If the patient is no longer in pain, the pain medication must be evaluated for tapering or stopping, depending on the dosage, length of treatment, and other factors.

d. Evaluation and Monitoring Mental Health - So much of chronic pain and the impact on a patient is related to one's mental health. Past and current mental health diagnoses and symptoms must be explored, both prior to prescribing controlled substances, but also on an ongoing basis when a patient is being prescribed controlled substances. Depending on the specifics, referral or consultation by a mental health specialist (e.g. Psychiatrist, Psychologist, etc.) may be indicated.

e. Excessive Prescribing - The determination of appropriate amounts of opioid/controlled substance medications is based on medically justified need. Prescribed amounts over the amount medically justified are excessive.

f. Dual Diagnosis - Defined as a patient with a mood (mental health) disorder (e.g. depression, bipolar, etc.) as well as problems with alcohol and/or drugs (e.g. abuse or addiction). These patients need management plans for both the mental health as well as their drug/alcohol disorders. Physicians with expertise in dual diagnosis are necessary for treatment, generally mental health/addiction medicine physicians, or a combination of physicians with these areas of expertise.

g. Quality of Life and Pain - Quality of life, pain control, improvement in function, and therapeutic safety are important factors to be considered and documented for continued pain medication use.

h. Discontinuation of Medication - This is a high priority when the pain has resolved or diminished. Significant efforts need to be made when possible to avoid prolonged treatment as this involves the risk for addiction, pseudo-addiction, tolerance, and development of Hyperalgesia.

i. Inconsistencies - When patients request opioid pain medication or refills, if inconsistencies are found in their history, medical presentation, or behaviors that don't match physical findings or other information, it may be necessary to withhold opioid medications, adjust treatment plans or take other actions.

j. Monitoring - Ongoing monitoring of Controlled Medication treatment is vital. This includes looking for end organ damage from the medications (e.g. liver and renal labs), confirmation that the patient is taking the medications and not diverting the medications (e.g. urine drug testing), etc.

k. Periodic Review - At each visit the physician must re-evaluate the "5-A's":

1) Presence or absence of Addictive behavior

2) Improved Activities of daily living (function)

3) Presence or absence of Aberrant behavior

4) Adequacy of pain management (Analgesia), and

5) Appropriate Affect or Mental Status

l. Multiple Pain Management Modalities - Physicians managing chronic pain must use multiple modalities, not solely opioid meditations. Pharmacologic modalities that include non-controlled medications are vital as are non-pharmacological treatments.

m. Follow-up Visits - At each follow-up visit, the physician needs to address some of the following issues:

1) Comfort levels and quality of life issues

2) Controlled medication related side effects

3) Functional status - with and without the medications

4) Possible aberrant behavior - drug-related behavior changes

5) Evidence of drug diversion (unusual urine drug screen findings, medications counts, etc.)

6) Side effects or complications of the medications

7) Random urine drug screens

8) Objective evaluation of pain level

Ordering Tests without Medical Justification

46. The standard of practice dictates that an appropriate prior exam (including sufficient components of vital signs, history of the presenting acute and chronic problems, past medical history, physical exam, testing, etc.) is necessary when seeing a patient and as a part of making a treatment plan. This is necessary prior to ordering test to have medical justification for the test.

Unprofessional Conduct Business and Professions Code Section 2234.

47. The standard of practice dictates that a physician must have substantial compliance with the standard of care.

Appropriate Prior Exam

48. The standard of practice dictates that physicians must perform an appropriate exam prior to prescribing controlled substances, a medically legitimate purpose within the usual professional practice.

Legitimate Medical Purpose

49. The standard of practice dictates that a physician's prescription requires a medical indication, a medically legitimate purpose within the usual professional practice.

Patient S.A.[2]

50. Patient S.A. is a 32-year-old male treated by Respondent from approximately January 2, 2012 through July 31, 2015. The primary diagnoses included: Lumbar radiculopathy, chronic

[2] The names of patients are kept confidential to protect their privacy rights, and, though known to Respondent, will be revealed to him upon receipt of a timely request for discovery.

low back pain, and left arm radial head pain, reportedly with a past surgery and peripheral neuropathy, due to a motor vehicle accident.

51. During this period patient S.A. was prescribed about 138 prescriptions for controlled substances, these were prescribed by Respondent, unless otherwise indicated as follows:

Date	Medication	Strength	Quantity	Pharmacy/Doctor
November 5, 2013	Hydrocodone - Acet	10/325 mg	60	CVS
October 28, 2013	Hydrocodone - Acet	10/325 mg	60	CVS
November 13, 2013	Hydrocodone - Acet	10/325 mg	45	CVS
November 17, 2013	Alprazolam	1mg	30	CVS
November 17, 2013	Hydrocodone - Acet	10/325 mg	60	CVS
November 26, 2013	Hydrocodone - Acet	10/325 mg	45	CVS
December 2, 2013	Hydrocodone - Acet	10/325 mg	45	CVS
September 6, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
September 12, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens
September 15, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
September 19, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
September 24, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens
September 28, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
October 6, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
October 11, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens
October 16, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
October 21, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens
October 26, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
October 31, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
November 5, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens Pham
November 13, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
November 19, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol
November 29, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol

November 30, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol	
December 7, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol	
December 14, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol	
December 20, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens	
December 26, 2012	Hydrocodone - Acet	10/325 mg	45	Walgreens	
December 31, 2012	Hydrocodone - Acet	10/325 mg	45	Bristol	
January 5, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
January 10, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
January 16, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
January 21, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
January 26, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
January 30, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
February 4, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
February 8, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
February 12, 2013	Hydrocodone - Acet	10/325 mg	60	Walgreens	
February 16, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
February 20, 2013	Hydrocodone - Acet	10/325 mg	49	Walgreens	Pham
February 26, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	
February 26, 2013	Hydrocodone - Acet	10/325 mg	49	Walgreens	Pham
February 26, 2013	Hydrocodone - Acet	10/325 mg	49	Walgreens	Pham
March 4, 2013	Hydrocodone - Acet	10/325 mg	49	Walgreen	Pham
March 9, 2013	Hydrocodone - Acet	10/325 mg	49	Bristol	Pham
March 14, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
March 14, 2013	Hydrocodone - Acet	10/325 mg	49	Walgreens	Pham
March 19, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	Pham
March 24, 2013	Hydrocodone - Acet	10/325 mg	20	Walgreens	Pham
March 24, 2013	Hydrocodone - Acet	10/325 mg	20	Walgreens	Pham
March 26, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	

March 30, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
March 30, 2013	Hydrocodone - Acet	10/325 mg	30	Walgreens	
April 3, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	Risser
April 9, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
April 12, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
April 13, 2013	Suboxone	2 mg	90	Walgreens	Pham
April 13, 2013	Buprenorphine	8	30	Walgreens	Pham
April 15, 2013	Hydrocodone - Acet	10/325 mg	60	Bristol	
June 24, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
July 18, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
September 20, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
September 26, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
October 2, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	Risser
October 8, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	Risser
October 10, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	Risser
October 14, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
October 19, 2013	Hydrocodone - Acet	10/325 mg	45	Rite Aid	
October 23, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	Risser
October 28, 2013	Hydrocodone - Acet	10/325 mg	60	Bristol	
November 1, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
November 5, 2013	Hydrocodone - Acet	10/325 mg	60	Bristol	
November 10, 2013	Hydrocodone - Acet	10/325 mg	45	Walgreens	Risser
November 13, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
November 17, 2013	Hydrocodone - Acet	10/325 mg	60	Bristol	
November 17, 2013	Alprazolam	1 mg	30	Bristol	
November 26, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	
November 27, 2013	Hydrocodone - Acet	10/325 mg	30	Walgreens	Risser
December 2, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol	

March 1, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol		
March 10, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
April 8, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
April 13, 2014	Hydrocodone - Acet	10/325 mg	30	Walgreens		
April 13, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
April 13, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
April 16, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol		
April 26, 2014	Hydrocodone - Acet	10/325 mg	45	Rite Aid		
April 30, 2014	Hydrocodone - Acet	10/325 mg	30	Walgreens		
May 5, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol		
May 10, 2014	Hydrocodone - Acet	10/325 mg	45	Rite Aid		
May 15, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
May 19, 2014	Hydrocodone - Acet	10/325 mg	45	Rite Aid		
May 23, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
May 28, 2014	Hydrocodone - Acet	10/325 mg	30	Bristol	Risser	
June 1, 2014	Hydrocodone - Acet	10/325 mg	60	Walgreens		
August 10, 2014	Hydrocodone - Acet	10/325 mg	60	Walgreens	Risser	
August 18, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol		
August 26, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol		
September 2, 2014	Hydrocodone - Acet	10/325 mg	60	Walgreens		
September 10, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol		
September 18, 2014	Hydrocodone - Acet	10/325 mg	60	Walgreens		
September 26, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol		
October 2, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol		
October 9, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens		
October 10, 2014	Hydrocodone - Acet	10/325 mg	30	Walgreens	Risser	
October 15, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol		
October 19, 2014	Alprazolam	1 mg	30	Bristol		

October 20, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol	
October 25, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol	Risser
November 3, 2014	Alprazolam	1 mg	30	Bristol	
November 3, 2014	Hydrocodone - Acet	10/325 mg	60	Bristol	
November 3, 2014	Alprazolam	1 mg	30	Walgreens	
November 3, 2014	Hydrocodone - Acet	10/325 mg	60	Walgreens	
November 12, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol	
November 18, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol	
November 25, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol	
November 25, 2014	Alprazolam	1 mg	30	Bristol	
November 30, 2014	Hydrocodone - Acet	10/325 mg	45	Bristol	
December 4, 2014	Hydrocodone - Acet	10/325 mg	45	Walgreens	
December 4, 2014	Alprazolam	1 mg	30	Walgreens	
January 3, 2015	Hydrocodone - Acet	10/325 mg	45	Bristol	
January 7, 2015	Hydrocodone - Acet	10/325 mg	45	Walgreens	Risser
January 12, 2015	Hydrocodone - Acet	10/325 mg	45	Walgreens	
January 19, 2015	Alprazolam	2 mg	45	Bristol	Risser
January 19, 2015	Hydrocodone - Acet	10/325 mg	60	Bristol	Risser
January 19, 2015	Alprazolam	2 mg	45	Bristol	Risser
January 19, 2015	Hydrocodone - Acet	10/325 mg	60	Bristol	Risser
January 19, 2015	Alprazolam	2 mg	15	Walgreens	Risser
January 19, 2015	Hydrocodone - Acet	10/325 mg	60	Walgreens	
February 26, 2015	Hydrocodone - Acet	10/325 mg	120	Rite Aid	Pham
February 26, 2015	Buprenorphine	8 mg	3	Rite Aid	Pham
February 26, 2015	Alprazolam	2 mg	30	Walgreens	Pham
March 4, 2015	Buprenorphine	8 mg	7	Rite Aid	Pham
March 9, 2015	Buprenorphine	8 mg	10	Rite Aid	Pham
March 13, 2015	Alprazolam	2 mg	60	Walgreens	Pham

March 14, 2015	Buprenorphine	8 mg	10	Rite Aid	Pham
March 17, 2015	Alprazolam	2 mg	60	Walgreens	Pham
March 24, 2015	Buprenorphine	8 mg	10	Rite Aid	Pham
April 15, 2015	Hydrocodone - Acet	10/325 mg	60	Bristol	
April 17, 2015	Alprazolam	2 mg	60	Walgreens	Pham
April 20, 2015	Alprazolam	2 mg	30	Walgreens	Pham
May 5, 2015	Alprazolam	2 mg	30	Walgreens	Pham
May 23, 2015	Hydrocodone - Acet	10/325 mg	45	Walgreens	
October 12, 2015	Amphata /Dextro	30 mg	90	WalMart	Pham
December 31, 2015	Alprazolam	2 mg	30	Rite Aid	Risser
February 22, 2016	Vyvanse	70 mg	30	Rite Aid	Pham
March 11, 2016	Amphata /Dextro	30 mg	90	WalMart	Pham
April 5, 2016	Amphata /Dextro	30 mg	90	WalMart	Pham
August 24, 2016	Amphata /Dextro	30 mg	90	WalMart	Pham

52. On November 7, 2013, patient S.A. was seen by Respondent at his office. His chief complaint was a twisted knee.

(a) The history and physical stated: Knee injury – concerned about possible tear – no significant swelling.

(b) The past medical history stated: neck and back pain, elbow pain, left radial head pain, anxiety, and insomnia.

(c) Review of systems stated: denies neck and back pain, positive knee injury pain, knee trauma pain.

(d) Physical exam stated: patient was noted to be in moderate distress Heart, Lung, and abdominal exam were very brief and normal "Pelvis – unremarkable" [no details] Extremity - + edema [no details] Neurological exam including DTR in sensory or normal.

(e) Assessment stated: Doubt ligament tear, if symptoms persist consider MRI Elbow and back – additional words were not legible.

(f) Plan: Knee brace, Norco 10/325 – #45 tablets

53. Patient S.A. was prescribed hydrocodone acetaminophen prescription and received, the following prescriptions which were filled in close proximity to this visit as follows:

A. November 1, 2013–45 tablets, prescribed by Respondent.

B. November 5, 2013–60 tablets, prescribed by Respondent.

C. November 10, 2013–45 tablets, prescribed by Dr. Rissser.

D. November 13, 2013–45 tablets, prescribed by Respondent.

This equals a total of approximately 195 tablets prescribed in a period of 13 days, 150 of these tablets were prescribed by Respondent.

54. On November 15, 2013, patient visited Respondent.

A. The chief complaint was: Medications for back and arm, back spasm, left arm, insomnia and anxiety. Much of the note was similar to the prior visit.

B. Exam: Neck – No exam. Back – paravertebral tenderness, decreased range of motion (ROM), plus Straight leg raising; sensory and strength normal. Extremity – Edema.

C. Assessment: Low back pain. Most of the words are not legible.

D. Plan: Appears to say "Therapy" and Return to clinic (RTC) in 1-2 weeks for follow-up. There is no documentation of prescribing Hydrocodone-Acet.

55. There is a gap in care from November 15, 2013 to March 1, 2014. There is no explanation in the record.

56. On March 1, 2014, patient S.A. visited Respondent. There is no information documented why patient S.A. had not been seen for nearly four and a half (4 and ½) months nor whether the patient had been receiving the pain medication from an outside source.

A. Chief complaint was: chest pain, shortness of breath, rapid breathing, and elbow pain. Patient had symptoms of fatigue, anxiety, headache, dizziness, back and elbow pain, palpitations.

B. Exam record stated: vital signs were normal including heart rate, respiratory rate, and temperature Exam – moderate to severe distress.

C. HEENT examination is a portion of a physical examination that principally concerns the head, eyes, ears, nose, and throat. The HEENT exam was essentially normal Long exam normal.

D. Heart exam normal Abdomen – "soft" Pelvic – "unremarkable".

E. Back exam showed para vertebral tenderness of the lumbosacral spine, decreased range of motion.

F. Extremities exam showed: edema.

G. Neurological exam showed: strength and sensory exams normal.

H. EKG was performed and was normal.

I. Stress echocardiogram was performed and was normal.

J. Assessment chest pain – doubt cardiac etiology remainder of the information was not legible Restart trigger injection and stimulation therapy.

K. Diagnoses listed include radiculopathy lumbosacral spine, anxiety, dizziness, fatigue, insomnia, chest pain, near syncope, headache, and left elbow pain.

57. On March 10, 2014, patient S.A. visited Respondent.

A. Chief complaint was: back and neck pain. Patient continues to complain of chronic back and neck pain Exam is essentially unchanged from prior visits Assessment and plan appears to be similar to prior visits.

B. The patient was given anti-inflammatory injection and Norco – number 45 tablets. Return to clinic in two weeks.

58. On March 14, 2014, patient S.A. visited Respondent.

A. Patient complained of cough, chest congestion, shortness of breath, E stem therapy.

B. Exam was essentially unchanged.

C. Diagnosis appears to state asthmatic bronchitis however the rest of the writing is not able to be deciphered. Pulse ox was performed and was 91% which is low

59. On March 25, 2014, patient S.A. visited Respondent. Patient was given Solu-Medrol and Toradol injections as well as Motrin and an analgesic cream.

60. On April 4, 2014, patient S.A. visited Respondent. Patient had an upper respiratory infection.

61. On April 10, 2014, patient S.A. visited Respondent. Patient was again seen for back pain and insomnia. Treatment appears to be about the same and legibility of medical records again is very poor and fairly little is written.

62. On April 16. 2014, patient S.A. visited Respondent. Patient had an upper respiratory infection and was given intramuscular Rocephin and oral Augmentin.

63. On January 19, 2015, patient S.A. visited Respondent. Patient was on Norco; also had a panic episode:

A. Complaints and review of systems are similar to prior visits

B. Exam shows moderate to severe distress

C. HEENT, lungs, heart, and abdomen are marked as essentially normal, Pelvic – "unremarkable"

D. No exam of the neck or back was documented

E. Extremities – "warm/dry"

F. Neurologic exam – strength and sensory intact. The medical record noted that Anxiety had been increased and reportedly had been tried on an SSRI with daytime somnolence. Xanax relieves anxiety with increased drowsiness.

G. Plan – Xanax is increased to 2 mg per day – 45 tablets prescribed, advised to avoid alcohol; Norco – number 30 tablets were prescribed.

64. On February 23, 2015, patient S.A. visited Respondent. Patient was seen for neck and back pain:

A. No mention was made in the medical records regarding panic attacks or details regarding anxiety.

B. The exam, assessment, and plan appear to be essentially the same; however, some of the information is not legible.

65. On May 17, 2015 and July 31, 2015, patient S.A. saw Respondent. At the second of those two visits, patient S.A. had pain in the neck radiating to the jaw, left arm and chest pain. The patient again had an EKG and a stress echo, both of which were normal. There is no mention why there was a three-month gap between the February and May appointments.

66. The medical records show that patient S.A. received trigger point injections on numerous occasions in the areas of the neck and back with reported improvement of symptoms according to the brief notes. The progress notes also have documentation of what it appeared to be therapy sessions of unknown type treating the patient's pain. This appears to be electrical stimulation and musculoskeletal education.

67. On April 13, 2013, Respondent prescribed Suboxone and buprenorphine to patient S.A. Soon following this date, Respondent prescribed more hydrocodone for the patient.

68. From March 4, 2015 through March 24, 2015, Respondent prescribed buprenorphine to patient S.A. On April 15, 2015 and again on May 23, 2015, Respondent prescribed hydrocodone to patient S.A.

69. Respondent prescribed dangerous drug combinations, and gave patient early refills.

70. The medical record chart documents no specific informed consent. There is also no imaging and no laboratory results.

Gross Negligence

71. Respondent's conduct, as described above generally and as specified below particularly, is subject to disciplinary action under Section 2234, Subdivision (b), in that he committed acts of gross negligence in his care and treatment of patient S.A. The circumstances are as follows:

A. Treatment Plan. The Respondent prescribed opioids and controlled substances without a documented justifiable treatment plan, discussion of treatment goals, and regular functional assessment and appropriate ongoing monitoring.

B. Ongoing Monitoring. The Respondent failed to perform and document the appropriate necessary monitoring while prescribing dangerous opioids and controlled substance medications on a frequent basis for a long period of time.

C. Unprofessional Conduct. The Respondent failed to follow multiple critical aspects of the Standards of Care in prescribing controlled substances to this patient multiple times. This highlights that the dangerous care exhibited by Respondent was not a rare occurrence, but his regular practice. This included:

1) Inadequate and insufficient history.
2) Inadequate exams.
3) Not obtaining imaging for patient with chronic pain.
4) Failing to document justification for the prescribing of controlled substances.
5) Failed to document discussing the specifics risk of the controlled substances.
6) Inadequately documented pain scores.
7) Failed to document discussing any treatment goals or functional assessment.
8) Failed to provide specific assessments.
9) Failed to document that alternative treatments were utilized other than E-stimulation and trigger point injections.
10) Failed to order referrals to orthopedist, physical medicine, or pain management, despite ongoing prescriptions for opioids and other controlled prescribed substances.
11) Failed to follow the necessary monitoring including: urine drug screens, CURES report and no liver function testing obtained despite multiple dosages of opioids.
12) ignored pharmacy red flags including multiple pharmacies, dangerous drug combinations, early refills, traveling long distances to see Respondent, and unexplained treatment gaps.

D. Code Section 2242. The Respondent failed to perform an appropriate prior exam or evaluation prior to prescribing controlled substances as described above.

E. Health and Safety Code Section 11154. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances as described above.

F. Prescribing Without a Medical Indication - Health and Safety Code Section 11153. Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances, and prescribed without medical indication as described above.

Patient A.B.

72. Patient A.B. is a 33-year-old female treated by Respondent from approximately September 14, 2013 to February 12, 2016. The primary diagnoses included: neck and back pain, migraine headaches, anxiety, attention deficit hyperactivity disorder and depression.

73. Respondent prescribed to patient A.B. as follows:

Date	Medication	Strength	Quantity	Pharmacy/Doctor
December 14, 2013	Hydrocodone - Acet	10/325 mg	30	Vons
December 14, 2013	Methylphenidate	36 mg	60	Vons
January 2, 2014	Alprazolam	2 mg	45	Vons
January 2, 2014	Hydrocodone - Acet	10/325 mg	45	Vons
September 14, 2013	Hydrocodone - Acet	10/325 mg	45	Bristol
October 23, 2013	Hydrocodone - Acet	10/325	45	Bristol
February 7, 2014	Hydrocodone - Acet	10/325	45	Bristol
February 24, 2014	Methylphenidate	36	60	Bristol
March 5, 2014	Cyclobenzaprine	10	21	Bristol
March 5, 2014	Hydrocodone - Acet	10/325	40	Bristol
March 11, 2014	Hydrocodone - Acet	10/325	60	Bristol
March 19, 2014	Cyclobenzaprine	10	45	Bristol

March 26, 2014	Methylphenidate	36	60	Bristol
April 10, 2014	Carisoprodol	350	30	Bristol
April 10, 2014	Tramadol	50	30	Bristol
April 21, 2014	Tramadol	50	30	Bristol
April 21, 2014	Carisoprodol	350	30	Bristol
April 30, 2014	Alprazolam	2	30	Bristol
April 30, 2014	Carisoprodol	350	30	Bristol
April 30, 2014	Methylphenidate	36	60	Bristol
April 30, 2014	Tramadol	50	60	Bristol
May 8, 2014	Tramadol	50	60	Bristol
May 8, 2014	Carisoprodol	350	30	Bristol
May 9, 2014	Cyclobenzaprine	10	45	Bristol
May 14, 2014	Carisoprodol	350	30	Bristol
May 16, 2014	Carisoprodol	350	30	Bristol
May 17, 2014	Tramadol	50	30	Bristol
May 22, 2014	Hydrocodone - Acet	10/325	45	Bristol
May 22, 2014	Tramado	50	45	Bristol
May 24, 2014	Carisoprodol	350	30	Bristol
May 27, 2014	Cyclobenzapri ne	10 mg	45	Bristol
May 31, 2014	Tramadol	50 mg	60	Bristol
May 31, 2014	Alprazolam	1 mg	60	Bristol
May 31, 2014	Methylphenidate	36 mg	60	Bristol
June 2, 2014	Carisoprodol	350 mg	30	Bristol
June 9, 2014	Hydrocodone - Acet	10/325	30	Bristol
June 17, 2014	Hydrocodone - Acet	10/325	30	Bristol
June 24, 2014	Hydrocodone - Acet	10/325	30	Bristol
July 3, 2014	Hydrocodone - Acet	10/325	30	Bristol
July 3, 2014	Methylphenidate	36	60	Bristol

July 12, 2014	Hydrocodone - Acet	10/325	30	Bristol
July 26, 2014	Methylphenidate	36	60	Bristol
July 26, 2014	Hydrocodone - Acet	10/325	45	Bristol
August 20, 2014	Hydrocodone - Acet	10/325	45	Bristol
September 1, 2014	Hydrocodone - Acet	10/325	45	Bristol
September 2, 2014	Methylphenidate	36	60	Bristol
September 12, 2014	Hydrocodone - Acet	10/325	45	Bristol
September 23, 2014	Hydrocodone - Acet	10/325	30	Bristol
October 2, 2014	Hydrocodone - Acet	10/325	30	Bristol
October 2, 2014	Methylphenidate	36	60	Bristol
October 8, 2014	Hydrocodone - Acet	10/325	30	Bristol
October 15, 2014	Hydrocodone - Acet	10/325	45	Bristol
October 27, 2014	Hydrocodone - Acet	10/325	60	Bristol
October 28, 2014	Methylphenidate	36	60	Bristol
February 12, 2016	Oxycodone - Acet	10/325	30	Bristol

74. Respondent made multiple additional prescriptions to patient A.B. from 2012 and 2013, including for Hydrocodone - Acet (>30), Methylphenidate, Diazepam.

75. Respondent had no Controlled Substance Agreement with patient A.B. Respondent had no Specific Informed Consent form with patient A.B. Respondent had no lab work done for patient A.B.

76. Respondent ordered imaging for patient A.B. as follows:

A. June 3, 2014, MRI of the left shoulder showed mild tendinosis of the supraspinatus and subscapularis tendons.

B. August 27, 2014, Doppler ultrasound of the legs showed no evidence of deep venous thrombosis.

77. Respondent performed the following procedures on patient A.B.:

A. April 8, 2014 – Carotid Doppler ultrasound – negative

B. Multiple trigger point injections – various locations of the body

C. May 30, 2014 – Pulmonary Function Testing

D. August 27, 2014 - Doppler ultrasound of the legs - normal

78. Respondent records were inadequate and inaccurate as follows:

A. The legibility of the handwriting was very poor and many words were not able to be deciphered.

B. Much of the current history, past medical history, and physical exam are indicated by lines through words or in checkboxes to indicate their presence or absence. Limited additional details are written on a second page, much of which is of minimal legibility.

C. None of the progress notes document current or past use or abuse of alcohol and or illicit drugs or addiction issues.

D. None of the progress notes record past medical history or current history of mental health issues other than stating "anxiety and insomnia." No further details were pursued or documented.

E. The specifics of the assessment are generally not included or are not legible in the note.

F. Much of the treatment plan is not legible and appears to be incomplete.

G. Most of the medications prescribed and listed on the pharmacy prescription listing are not documented in the progress note.

H. Over the span of management by Respondent, the patient failed to show much or any improvement from visit one to the final visit.

79. On January 31, 2014, patient A.B. visited Respondent. Patient A.B. complained of respiratory infection, shortness of breath, chest congestion, and migraine headaches. Chronic problems include back pain, neck pain, ADHD, anxiety, depression, hypertension. Chart notes that day reflect the following:

A. Exam – no respiratory distress.

B. HEENT, heart, lungs, abdomen Pelvic exam – "unremarkable". Neck showed tenderness to palpation, decreased range of motion.

C. Assessment: Decreased range of motion.

D. Plan: Solu-Medrol IM, Rocephin injection Norco. Multiple other words that are not legible.

80. On February 8, 2014, Patient A.B. visited Respondent. Patient A.B. was treated for an upper respiratory infection. No musculoskeletal exam was performed. Many of the following visits included injections for Toradol and Solu-Medrol for the patient, multiple appointments for trigger injections, and physical therapy including E-stimulus.

81. On February 16, 2014, patient A.B. visited Respondent complaining of neck pain and back pain, muscle stiffness, myalgias, headache, weakness, fatigue, nausea. Chart notes that day reflect the following:

A. Exam stated: muscle tenderness and decreased range of motion in the neck, upper and lower back, positive straight leg raising test of the legs.

B. Neurological test was negative.

C. Assessment and Plan: Toradol and Solu-Medrol given. Additional words were not legible.

82. On February 24, 2014, patient A.B. visited Respondent complaining of back and neck pain. Chart notes that day reflect the following:

A. Exam was essentially unchanged.

B. Assessment and Plan – not legible. The Patient was started on methylphenidate however there is no documented evaluation regarding ADHD.

83. On March 4, 2014, patient A.B. again visited Respondent; this time complaining of knee pain. An examination of the knee was performed at this visit. Patient A.B. was given Toradol and a prescription for hydrocodone – acetaminophen.

84. On March 12, 2014, patient A.B. visited Respondent. The progress note mentions ADHD; however, there was no additional information and no documentation of any evaluation.

85. On April 8, 2014, patient A.B. visited Respondent complaining of dizziness, chest pain, and "heart beating in the neck." The documented exam was essentially unchanged and vital signs were stable. Carotid ultrasound was negative, stress echo was negative, EKG showed mild T-wave abnormalities. It was highly unlikely carotid ultrasound and stress echo was indicated in a patient of this age. The Plan was not legible.

86. On May 30, 2014, patient A.B. visited Respondent complaining of sinus pressure and discomfort as well as her chronic problems. A pulmonary function test showed moderate resistive changes with improvement with bronchodilators. Patient A.B. was treated with Rocephin antibiotic and given alprazolam for insomnia.

87. On June 8, 2014, patient A.B. visited Respondent. She complained of back and neck pain as well as headaches and muscle spasms. Patient A.B. had chronic back pain listed as well. Chart notes for this visit reflect the following:

A. Exam is essentially unchanged.

B. Plan – patient was given injections for Toradol and Solu-Medrol as well as a prescription for hydrocodone – acetaminophen. Patient received multiple prescriptions for hydrocodone for the next four months. The prescriptions were given every 7 to 14 days frequently.

88. On June 3, 2014, patient A.B. visited Respondent. An MRI of the left shoulder showed mild tendinosis of the supraspinatus and subscapularis tendons.

89. On August 27, 2014 Doppler ultrasound of the legs showed no evidence of deep venous thrombosis.

90. On October 20, 2014, patient A.B. was again treated for neck and back pain. The exam and assessment and plan appeared essentially unchanged. Multiple words in the chart note for this date are not legible. Patient A.B. was given injections of Toradol and Solu-Medrol.

91. The only progress note in the records for patient A.B. was dated May 20, 2013, which states that patient A.B. had gained weight during her freshman year of college and would like to start HCG. Patient A.B. was started on HCG 500 international units per day. There was no other history, past medical history, or physical exam included. There were no other tests including

laboratory, imaging, etc., in the records. There was also one sheet dated February 24, 2013. The sheet only lists medications and supplement directions, however, there was no associated note including history, exam, assessment, or plan. The information on the sheet included antibiotics: Azithromycin and soft laxative. Also listed was a "strong anti-inflammatory," dexamethasone. There was also a cough medicine and Neosynephrine.

Gross Negligence

92. Respondent's conduct, as described above generally and as specified below particularly, is subject to disciplinary action under Section 2234, Subdivision (b), in that he committed acts of gross negligence in his care and treatment of patient A.B. The circumstances are as follows:

A. Treatment Plan and Management Goals. The Respondent prescribed opioids and controlled substances without a documented justifiable treatment plan, discussion of treatment goals, and regular functional assessment and appropriate ongoing monitoring.

B. Informed Consent. The Respondent failed to document discussing the major potential risk of the Controlled Substances despite prescribing many dangerous medications, including a potential combination of opioid and benzodiazepine medications.

C. Ongoing Monitoring. The Respondent failed to perform and document the appropriate necessary monitoring while prescribing dangerous opioids and controlled substance medications on a frequent basis for a long period of time.

D. Unprofessional Conduct. The Respondent failed to follow multiple critical aspects of the Standards of Care in prescribing controlled substances to this patient multiple times. This highlighted that the dangerous care exhibited by Respondent was not a rare occurrence, but his regular practice. This included:

1) Inadequate and insufficient history.

2) Inadequate exams.

3) Not obtaining imaging for patient with chronic pain.

4) Failing to document justification for the prescribing of controlled substances.

5) Failed to document discussing the specifics risk of the controlled substances.

6) Inadequately documented pain scores.

7) Failed to document discussing any treatment goals or functional assessment.

8) Failed to provide specific assessments.

9) Failed to document that alternative treatments were utilized other than E-stimulation and trigger point injections.

10) Failed to order referrals to orthopedist, physical medicine, or pain management, despite ongoing prescriptions for opioids and other controlled prescribed substances.

11) Failed to follow the necessary monitoring including: urine drug screens, CURES report and no liver function testing obtained despite multiple dosages of opioids.

12) Ignored pharmacy red flags including multiple pharmacies, dangerous drug combinations, early refills, traveling long distances to see Respondent, and unexplained treatment gaps.

E. Code Section 2242. The Respondent failed to perform an appropriate prior exam or evaluation prior to prescribing controlled substances as described above.

F. Health and Safety Code Section 11154. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances as described above.

G. Prescribing Without a Medical Indication - Health and Safety Code Section 11153. The Respondent failed to perform an appropriate history, exam or

additional evaluation prior to prescribing and refilling controlled substances, and prescribed without medical indication as described above.

H. Evaluation and Management of ADHD. The Respondent prescribed Methylphenidate without an appropriate evaluation and without appropriate ongoing monitoring.

Patient C.B.

93. Patient C.B. is a 32-year-old male treated by Respondent from approximately January 2, 2012 through July 31, 2015. The primary diagnoses included: anxiety, chronic neck and back spasm/pain, and attention deficit hyperactivity disorder.

94. Respondent prescribed to patient C.B. as follows:

Date	Medication	Strength	Quantity	Pharmacy/Doctor
December 14, 2013	Oxycodone	30 mg	30	Vons
December 31, 2013	Hydrococone - Acet	10/325 mg	45	CVS
January 7, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
January 23, 2013	Oxycodone	10 mg	45	Bristol
February 15, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
February 19, 2013	Cheratussin AC	liq	240	Safeway
February 26, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
March 11, 2013	Oxycodone	10 mg	45	Bristol
March 21, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
March 27, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
April 15, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
May 8, 2013	Oxycodone - Acet	5-325 mg	20	Safeway/Nakashioya
May 16, 2013	Oxycodone	10 mg	45	Bristol
May 21, 2013	Hydrocodone - Acet	5-325 mg	40	Safeway/Bikhazi
May 31, 2013	Oxycodone	30 mg	30	Safeway
June 14, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
June 22, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway

June 26, 2013	Oxycodone	30 mg	60	Safeway
June 27, 2013	Hydrocodone - Acet	10-325 mg	30	Safeway
December 14, 2013	Oxycodone	30 mg	30	Safeway
January 15, 2014	Hydrocodone - Acet	10-325 mg	30	Safeway

95. Respondent's treatment of patient C.B. was insufficient as follows:

A. Exam. The exam performed by Respondent was generally the same at every visit.

B. Imaging. Despite treating this patient for chronic pain, no imaging was obtained at all pertaining to the areas of pain.

C. Justification of Treatment. There was no justification documented for prescribing Controlled Substance medications, based on the information reviewed.

D. Discussion of Risks with the Patient. Respondent failed to document discussion of the specific risks of the controlled substance medications with patient.

E. Pain Scores were rarely if ever documented.

F. Discussion of Treatment Goals and Functional Assessment. The physician does not document discussing with the patient any treatment goals or functional assessment as required.

G. Assessment - Specifics generally were not included.

H. Prescriptions - Many of the prescriptions found on the Pharmacy Patient Profile were not documented in the medical records.

I. Alternative Treatments - There was no evidence that alternative treatments were utilized, other than the E-stimulus and trigger point injections performed in the Irvine Urgent Care Office.

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J. Referrals - Despite ongoing prescriptions for opioids and other controlled substances, no referrals were ordered. (e.g. Orthopedics, Physical Medicine, Pain Management, etc.).

K. Tests were performed without Documentation of Indication Imaging as follows:

1) October 4, 2012 – Legs arterial ultrasound – normal
2) October 4, 2012 – Legs venous ultrasound – normal
3) February 26, 2013 – Carotid Doppler ultrasound – normal
4) May 23, 2014 – Bilateral carotid artery ultrasound –negative study
5) July 26, 2014 - Bilateral ultrasound of the lower extremities – normal

Procedures:

6) February 25, 2013 – Stress Echocardiogram – normal.
7) March 20, 2013 – Echocardiogram – normal.
8) May 23, 2014 Stress echocardiogram was also performed again and this was normal.

L. Medication Monitoring - The physician failed to follow the monitoring necessary, which may include:

1) Urine drug screens. No Urodynamics Study (UDS) tests are documented.
2) CURES report – none checked.
3) No liver function testing obtained despite multiple dosages of opioids.
4) Pharmacy Red Flags were ignored.
5) Multiple pharmacies were used.
6) Dangerous drug combinations were prescribed.
7) Early refills were requested.

Gross Negligence

96. Respondent's conduct, as described above generally and as specified below particularly, is subject to disciplinary action under Section 2234, Subdivision (b), in that he committed acts of gross negligence in his care and treatment of patient C.B. The circumstances are as follows:

A. Treatment Plan and Management Goals. Respondent prescribed controlled substance prescriptions for this patient without a documented justifiable treatment plan, discussion of treatment management goals, and regular functional assessment and appropriate ongoing monitoring.

B. Informed consent. Respondent failed to document discussing the major potential risk of the controlled substances despite prescribing many dangerous medications, including a potential combination of opioid and benzodiazepine medications.

C. Ongoing Monitoring. Respondent failed to perform and document the appropriate necessary monitoring while prescribing dangerous opioids and controlled substances on a frequent basis for a long period of time.

D. Unprofessional Conduct. The Respondent failed to follow multiple critical aspects of the Standards of Care in prescribing controlled substances to this patient multiple times. This highlights that the dangerous care exhibited by respondent was not a rare occurrence, but his regular practice. This included:

1) Inadequate and insufficient history.
2) Inadequate exams.
3) Not obtaining imaging for patient with chronic pain.
4) Failing to document justification for the prescribing of controlled substances.
5) Failed to document discussing the specifics risk of the controlled substances.
6) Inadequately documented pain scores.
7) Failed to document discussing any treatment goals or functional assessment.
8) Failed to provide specific assessments.
9) Failed to document that alternative treatments were utilized other than E-stimulation and trigger point injections.

10) Failed to order referrals to orthopedist, physical medicine, or pain management, despite ongoing prescriptions for opioids and other controlled prescribed substances.

11) Failed to follow the necessary monitoring including: urine drug screens, CURES report and no liver function testing obtained despite multiple dosages of opioids.

12) Ignored pharmacy red flags including multiple pharmacies, dangerous drug combinations, early refills, traveling long distances to see Respondent, and unexplained treatment gaps.

E. Code Section 2242. Failed to perform an appropriate prior exam or evaluation prior to prescribing controlled substances as described above.

F. Health and Safety Code Section 11154. Failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances as described above.

G. Prescribing without a medical indication - Health and Safety Code section 11153. Failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances, and prescribed without medical indication as described above.

H. Documentation of the Indication for Procedures Ordered. Respondent ordered the following test and procedures without documenting the above needed items. Most of these would be extremely rare in a patient of this age. The diseases for which these were looking were rare in one in the 30 age range and if there was an indication, it would require detailed documentation of the indication, of which was not present. These tests were performed in the office of Respondent and were billed to insurance, however, documentation of the need for the tests was missing.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

97. Respondent is subject to disciplinary action under Code Section 2234, subdivision (c), in that he was repeatedly negligent in the care and treatment of his patients. The facts and circumstances alleged above in the First Cause for Discipline are incorporated here as if fully set forth and as follows:

The Completeness and Appropriateness of the History and Examination

98. The standard of practice dictates that an appropriate prior exam (including sufficient components of vital signs, history of the presenting acute and chronic problems, past medical history, physical exam, testing, etc.) is necessary when seeing a patient and as a part of making a treatment plan. This history and exam must also be documented in the medical records. All of the components listed may not be needed for every presenting problem or visit; many diagnoses may be made without laboratory or imaging testing, but these must be considered. Performing the necessary elements and medical record documentation of these is vital.

99. An exam appropriate for the presenting complaint, or chronic diagnosis, is vital and is standard of care. For chronic problems, repeated exams are vital to better identify changes in condition, success or failure of treatment, etc. On occasion an examination of the patient may not be necessary and the patient may be treated presumptively; however, this must be clearly documented.

100. For patients taking controlled substances, periodic updates of the history and examination are vital. If the patient is stable or under good control, the history and exam must be done at least every six months. If the patient is not stable, or not well controlled, more frequent updates need to be done. Pain requiring an advancement of dosing or change in therapy needs an updated history and exam. The written documentation must include and accurately reflect at least key aspects of the history and exam pertinent to the patient's presenting issues.

Adequacy of the Medical Records

101. The standard of practice dictates that documentation must be sufficient for the presenting problems or complaints, including sufficient components of history, review of

symptoms, physical exam, etc. All of the components listed may not be needed for every presenting problem and visit. Many diagnoses may be made without laboratory or imaging testing, but these must be considered.

a. The documentation of the history must be sufficient to determine the diagnosis, or most probable diagnosis, or whether the condition is stable or unstable, giving guidance to the needed exam, additional tests, etc.

b. The documentation must document and accurately reflect at least key aspects of the history and exam pertinent to the patient's presenting issues.

c. The chart must be legible for review by trained medical professionals. There are many purposes for the medical record, including to provide clinical information regarding what was stated and done at the visit for the treating provider as a reminder, for other providers who may care for the patient in the future, for quality reviews, for billing purposes, and other purposes. It is vital that this information is legible; otherwise the information is useless and could potentially cause harm.

Documentation of the Indication for Procedures Ordered

102. The Standards of Care requires that one documents the indication when a procedure or test is ordered. The risks, benefits, and risks of refusal need to be documented. Procedures or tests to be obtained must have a reasonable indication.

Patient S.A.

103. Respondent's conduct, as described above generally and as specified below constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omission in the care and treatment of Patient S.A. as follows:

A. Treatment Plan. Prescribed opioids and controlled substances without a documented justifiable treatment plan, discussion of treatment goals, and regular functional assessment and appropriate ongoing monitoring.

B. Ongoing Monitoring. Failed to perform and document the appropriate necessary monitoring while prescribing dangerous opioids and controlled substance medications on a frequent basis for a long period of time.

C. Unprofessional Conduct. Failed to follow multiple critical aspects of the Standards of Care in prescribing controlled substances to this patient multiple times. This highlights that the dangerous care exhibited by respondent was not a rare occurrence, but his regular practice. This included:

1) Inadequate and insufficient history.

2) Inadequate exams.

3) Not obtaining imaging for patient with chronic pain.

4) Failing to document justification for the prescribing of controlled substances.

5) Failed to document discussing the specifics risk of the controlled substances.

6) Inadequately documented pain scores.

7) Failed to document discussing any treatment goals or functional assessment.

8) Failed to provide specific assessments.

9) Failed to document that alternative treatments were utilized other than E-stimulation and trigger point injections.

10) Failed to order referrals to orthopedist, physical medicine, or pain management, despite ongoing prescriptions for opioids and other controlled prescribed substances.

11) Failed to follow the necessary monitoring including: urine drug screens, CURES report and no liver function testing obtained despite multiple dosages of opioids.

12) Ignored pharmacy red flags including multiple pharmacies, dangerous drug combinations, early refills, traveling long distances to see Respondent, and unexplained treatment gaps.

D. Code Section 2242. The Respondent failed to perform an appropriate prior exam or evaluation prior to prescribing controlled substances as described above.

E. Health and Safety Code Section 11154. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances as described above.

F. Prescribing Without a Medical Indication - Health and Safety Code Section 11153. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances, and prescribed without medical indication as described above.

G. History and Physical Exam. The Respondent failed to perform and document an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances, failed to write legible progress notes, failed to include initial and ongoing mental health and alcohol/drug use history, failed to discuss and document the major potential risks of the Controlled Substances.

H. Informed Consent. The Respondent failed to document discussing the major potential risks of the Controlled Substances despite prescribing many dangerous medications, including a potential combination of opioid and benzodiazepine medications. Only limited information was included on the controlled substance agreement and it is not clear this was discussed with the patient.

I. Records Documentation. The Respondent failed to perform and document an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances, failed to write legible progress notes, failed to include initial and ongoing mental health and alcohol/drug use history, failed to discuss and document the major potential risks of the Controlled Substances, and additional documentation issues listed above.

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Patient A. B.

104. Respondent's conduct, as described above and as specified below, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient A.B. as follows:

A. Treatment Plan and Management Goals. The Respondent prescribed opioids and controlled substances without a documented justifiable treatment plan, discussion of treatment goals, and regular functional assessment and appropriate ongoing monitoring.

B. Informed Consent. The Respondent failed to document discussing the major potential risk of the Controlled Substances despite prescribing many dangerous medications, including a potential combination of opioid and benzodiazepine medications.

C. Ongoing Monitoring. The Respondent failed to perform and document the appropriate necessary monitoring while prescribing dangerous opioids and controlled substance medications on a frequent basis for a long period of time.

D. Unprofessional Conduct. The Respondent failed to follow multiple critical aspects of the Standards of Care in prescribing controlled substances to this patient multiple times. This highlighted that the dangerous care exhibited by Respondent was not a rare occurrence, but his regular practice. This included:

1) Inadequate and insufficient history.
2) Inadequate exams.
3) Not obtaining imaging for patient with chronic pain.
4) Failing to document justification for the prescribing of controlled substances.
5) Failed to document discussing the specifics risk of the controlled substances.
6) Inadequately documented pain scores.

7) Failed to document discussing any treatment goals or functional assessment.

8) Failed to provide specific assessments.

9) Failed to document that alternative treatments were utilized other than E-stimulation and trigger point injections.

10) Failed to order referrals to orthopedist, physical medicine, or pain management, despite ongoing prescriptions for opioids and other controlled prescribed substances.

11) Failed to follow the necessary monitoring including: urine drug screens, CURES report and no liver function testing obtained despite multiple dosages of opioids.

12) Ignored pharmacy red flags including multiple pharmacies, dangerous drug combinations, early refills, traveling long distances to see Respondent, and unexplained treatment gaps.

E. Code Section 2242. The Respondent failed to perform an appropriate prior exam or evaluation prior to prescribing controlled substances as described above.

F. Health and Safety Code Section 11154. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances as described above.

G. Prescribing without a medical indication Health and Safety Code Section 11153. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances, and prescribed without medical indication as described above.

H. Evaluation and Management of ADHD. The Respondent prescribed Methylphenidate without an appropriate evaluation and without appropriate ongoing monitoring.

I. History and Physical Exam. The Respondent failed to perform and document an adequate and appropriate history and physical exam prior to prescribing and/or

refilling controlled substances, failed to write legible progress notes, failed to include initial and ongoing mental health and alcohol/drug use history, failed to discuss and document the major potential risks of the Controlled Substances.

J. Records Documentation. The Respondent failed to perform and document an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances, failed to write legible progress notes, failed to include initial and ongoing mental health and alcohol/drug use history, failed to discuss and document the major potential risks of the Controlled Substances, and additional documentation issues listed above.

K. The following tests were obtained by Respondent without documenting the medical indication for these tests. These tests were performed in the office of Respondent and were billed to insurance, however documentation of the need for the tests were missing.

1) On April 8, 2014, the results of a Carotid Doppler ultrasound were negative. This test would very rarely be indicated in a younger patient as carotid atherosclerosis is extremely rare at this age. This is not an appropriate test to evaluate near syncope or dizziness.

2) On August 27, 2014, the results of a Doppler ultrasound of the legs were normal.

Patient C.B.

105. Respondent's conduct, as described above and as specified below, constitutes unprofessional conduct and represents repeated negligent acts, in that Respondent committed errors and omissions in the care and treatment of Patient C.B. as follows:

A. Treatment Plan and Management Goals. Respondent prescribed controlled substance prescriptions for this patient without a documented justifiable treatment plan, discussion of treatment management goals, and regular functional assessment and appropriate ongoing monitoring.

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B. Informed Consent. Respondent failed to document discussing the major potential risk of the controlled substances despite prescribing many dangerous medications, including a potential combination of opioid and benzodiazepine medications.

C. Ongoing Monitoring. Respondent failed to perform and document the appropriate necessary monitoring while prescribing dangerous opioids and controlled substances on a frequent basis for a long period of time.

D. Unprofessional Conduct. Failed to follow multiple critical aspects of the Standards of Care in prescribing controlled substances to this patient multiple times. This highlights that the dangerous care exhibited by respondent was not a rare occurrence, but his regular practice. This included:

1) Inadequate and insufficient history.
2) Inadequate exams.
3) Not obtaining imaging for patient with chronic pain.
4) Failing to document justification for the prescribing of controlled substances.
5) Failed to document discussing the specifics risk of the controlled substances.
6) Inadequately documented pain scores.
7) Failed to document discussing any treatment goals or functional assessment.
8) Failed to provide specific assessments.
9) Failed to document that alternative treatments were utilized other than E-stimulation and trigger point injections.
10) Failed to order referrals to orthopedist, physical medicine, or pain management, despite ongoing prescriptions for opioids and other controlled prescribed substances.

11) Failed to follow the necessary monitoring including: urine drug screens, CURES report and no liver function testing obtained despite multiple dosages of opioids.

12) ignored pharmacy red flags including multiple pharmacies, dangerous drug combinations, early refills, traveling long distances to see Respondent, and unexplained treatment gaps.

E. Code Section 2242. The Respondent failed to perform an appropriate prior exam or evaluation prior to prescribing controlled substances as described above.

F. Health and Safety Code Section 11154. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances as described above.

G. Prescribing without a medical indication - Health and Safety Code Section 11153. The Respondent failed to perform an appropriate history, exam or additional evaluation prior to prescribing and refilling controlled substances, and prescribed without medical indication as described above.

H. Documentation of the Indication for Procedures Ordered. Respondent ordered the following test and procedures without documenting the above needed items. Most of these would be extremely rare in a patient of this age. The diseases for which these were looking were rare in one in the 30 age range and if there was an indication, it would require detailed documentation of the indication, of which was not present. These tests were performed in the office of Respondent and were billed to insurance, however documentation of the need for the tests was missing.

I. History and Physical Exam. The Respondent failed to perform and document an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances, failed to write legible progress notes, failed to include initial and ongoing mental health and alcohol/drug use history, failed to discuss and document the major potential risks of the Controlled Substances.

J. Records Documentation. The Respondent failed to perform and document an adequate and appropriate history and physical exam prior to prescribing and/or refilling controlled substances, failed to write legible progress notes, failed to include initial and ongoing mental health and alcohol/drug use history, failed to discuss and document the major potential risks of the Controlled Substances, and additional documentation issues listed above.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty)

106. The Respondent is subject to disciplinary action under Code Section 2234, subdivision (e), in that he failed to maintain adequate and accurate records relating to the provision of medical services to Patients S.A., A.B., and C.B. The fact and circumstances alleged above in the First and Second Cause for Discipline, are incorporated here as if fully set forth.

107. On May 30, 2016, Respondent wrote a letter to the California Department of Consumer Affairs (Division of Investigation). He wrote regarding the three patients for whom his care was under investigation. He stated he wanted to give some insight into their facility and operation. In that letter, Respondent dishonestly stated that:

A. Their medical and imaging center has been providing services in Irvine and the surrounding community for approximately a decade. They provide patient evaluation and diagnostics with short and long-term therapeutic care. The personnel care for patients with medical problems including acute trauma, cardiopulmonary, vascular, mental-health, neoplastic, and musculoskeletal disease. They also have diagnostic imaging including full body ultrasound, computed tomography scanning, magnetic resonance imaging, radiography, and a full laboratory. The staff includes three full-time physicians plus a full-time radiology team and approximately 20 other healthcare professionals and employees.

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B. Their standard protocols include requiring a history and physical exam documentation, pertinent diagnostic imaging or testing, formulation of treatment plans, and follow-up plans for each visit.

C. That regarding pain management and controlled substance medications, their personnel are aware of the need to monitor controlled substance usage and they comply with current Standards of Care. They periodically revisit physical evaluations and risk assessment and their guidelines include updated treatment plans and diagnostic evaluation including imaging if necessary. Treatment plans include pharmaceutical intervention, physical therapy, home exercise regimen regimens, electrical stimulation therapy, trigger point injections and joint injections. Prescriptions include non-steroidal or steroidal anti-inflammatory medications, analgesic and anti-inflammatory creams, and other non-controlled medications. These are used in conjunction with Schedule II or Schedule III medications as indicated.

D. Their monitoring for controlled substances has evolved in recent years. They now include the use of the Controlled Substance Utilization and Review Evaluation System (CURES) reports, pain and mental health questionnaires, urine drug screens, and specialty referrals. Staff members are cognizant of the need to monitor controlled substance dispensing. They routinely review and modify pain management protocols.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Prior Exam)

108. The Respondent is subject to disciplinary action under Code Section 2242, in that he prescribed and refilled without appropriate prior exams to Patients S.A., A.B., and C.B. The fact and circumstances alleged above in the First through Third Cause for Discipline, are incorporated here as if fully set forth.

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FIFTH CAUSE FOR DISCIPLINE

(Prescribed without Medical Indication)

109. The Respondent is subject to disciplinary action under Health and Safety Code Section 11154, in that he prescribed medication including controlled substances to Patients S.A., A.B., and C.B, without medical indication. The fact and circumstances alleged above in the First through Fourth Cause for Discipline, are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Prescribed without Legitimate Medical Purpose)

110. The Respondent is subject to disciplinary action under Health and Safety Code Section 11153, in that he prescribed medication including controlled substances to Patients S.A., A.B., and C.B, without legitimate medical purpose. The fact and circumstances alleged above in the First through Fifth Cause for Discipline, are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

111. The Respondent is subject to disciplinary action under Code Section 2266, in that he failed to maintain adequate and accurate records relating to the provision of medical services to Patients S.A., A.B., and C.B. The fact and circumstances alleged above in the First through Sixth Cause for Discipline, are incorporated here as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

112. The Respondent is subject to disciplinary action under Code Section 2234 in that he engaged in unprofessional conduct in care and treatment of Patients S.A., A.B., and C.B The facts and circumstances alleged above in the First through Seventh Cause for Discipline, are incorporated here as if fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 73459, issued to Omid Vesal, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to Section 3527 of the Code;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 13, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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